

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

08361 302  
Reg. Diat. No. ....

## 1. PLACE OF DEATH:

County..... Washington

City or town..... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 64 years

Hospital, Institution, or street address where death occurred:

230 Frederick St.

How long in hospital or institution?.....

## 3. (a) FULL NAME

Alice M. Adams

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

female

white

married

6.(b) Name of husband or wife.....

Henry Adams

7. Birth date of deceased (mo., day, yr.)

January 9, 1878

6.(c) If alive, give age..... 72 years

8. AGE:

Years  
69Months  
8Days  
11

If less than one day

hrs. ..... min.

9. Birthplace..... Middletown, Fred. Co., Md.

(Town, county, and state)

10. Usual occupation.....

housewife

11. Industry or business

12. Name..... Samuel S. Thompson

13. Birthplace..... Adams Co., Penna.

14. Maiden name..... Susan E. Cramer

15. Birthplace..... near Smithsburg, Md.

16. Informant..... Edward L. Thompson

Address..... Hagerstown, Md.

17. burial

(Burial, cremation, or removal. Which?)

Date thereof..... 9-24-47

(month) (day) (year)

Cemetery or crematory..... Rose Hill Cemetery

Location..... Hagerstown, Md.

18. Funeral director..... Scott F. Minnich &amp; Son

Address..... Hagerstown, Md.

Sept. 23, 1947 East Flowerd.  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... Washington

City or town..... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 230 Frederick St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 20, 1947, 11:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19, 1942, to June 19, 1942,

and that I last saw her alive on Sept. 1, 1947.

Immediate cause of death.....

Vascular hypertension

DURATION

7 yrs

Due to.....

chr. myocardial valvular  
arteriosclerotic heart disease

Due to..... 6 yrs

Other conditions..... acute ventricular fibrillation

(Include pregnancy within 3 months of death)

Major findings of operations..... no

Date of op.

no

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

no

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....

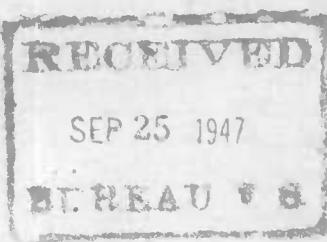
Robert Wells, M.D.

M.D. on other

Sept. 22/4

Address.....

Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

68362

## CERTIFICATE OF DEATH

Reg. Diat. No. 303

## 1. PLACE OF DEATH:

County WASHINGTONCity or town RURAL - HAGERSTOWN  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 WKS.Hospital, institution, or street address where death occurred:  
GATE WAY NURSING HOMEHow long in hospital or institution? 2 WKS.

## 3. (a) FULL NAME

LOTTIE CATHERINE ALTER

## 3. (b) Social Security Number

NONE

## 4. Sex

## 5. Color or race

## 6.(a) Single, married, widowed, or divorced

FEMALE WHITE WIDOWED.

## 6.(b) Name of husband or wife

JOHN E. ALTER

## 7. Birth date of deceased (mo., day, yr.)

NOVEMBER 2, 1888

## 6.(c) If alive, give age years

## 8. AGE:

Years	Months	Days	If less than one day
58	10	1	hrs. min.

## 9. Birthplace

EDGEMONT WASH., MARYLAND  
(Town, County, and state)

## 10. Usual occupation

## 11. Industry or business

## MOTHER FATHER

GEORGE RIDGE

12. Name

MARYLAND

13. Birthplace

CLARA BELLE WILHIDE

14. Maiden name

MARYLAND

15. Birthplace

MARYLAND

16. Informant

Mrs. Marshall Moore (daughter)

Address

215 E Washington St., Hagerstown

17. Burial

Date thereof 9/3/47

(Burial, cremation, or removal? Which?)

(month) (day) (year)

Cemetery or crematory

Wolff's Church Cemetery

Location

Greencastle, Md.

18. Funeral director

W. J. Horment

Address

Hagerstown, Md.

19. Death

Sept. 19, 1947

(Date rec'd by registrar)

Terry M. Tscheller

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WASHINGTONCity or town HAGERSTOWN  
(If outside city or town limits, write RURAL and give nearest town)Street No. 22 N Potomac ST  
(If rural, give LOCATION)2.(a) If veteran, name war Non-VET

## MEDICAL CERTIFICATION

DS.T.

20. DATE OF DEATH SEPTEMBER 3 1947 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

AUGUST 13 1947 to SEPT 3 1947and that I last saw her alive on SEPTEMBER 2 1947.

## Immediate cause of death

CARCINOMA OF RECTUM WITH METASTASISDoctor Metastasis

DURATION

?

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations SAMEapproximately  
Date of op. 1 year agoAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?)

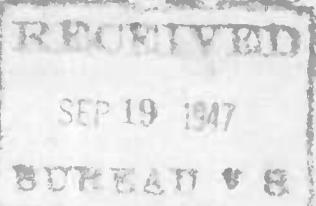
## Means of injury

Injured at work?

23. SIGNATURE Archie Robert Cohen

M. D.

Address Clean Spring Ford Date signed 9/3/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

08303

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:  
 County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 years  
 Hospital, institution, or street address where death occurred:  
 Washington County Hospital  
 D O A  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1020 Pope Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war World War II

3. (a) FULL NAME William F. Ankeney Jr.

3. (b) Social Security Number  
 219-12-2133

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Married
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6. (b) Name of husband or wife Beulah Ankeney

7. Birth date of deceased (mo., day, yr.) July 15, 1924

8. AGE: Years 23	Months 1	Days 22	If less than one day hrs. .... min.
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9. Birthplace Martinsburg, W. Va.  
 (Town, county, and state)

10. Usual occupation Employee of Victor Products Corp.

11. Industry or business

12. Name William F. Ankeney  
 13. Birthplace Clear Spring, Md.

14. Maiden name Wilma Phelps  
 15. Birthplace Waverly, New York

16. Informant William F. Ankeney Sr.  
 Address 1020 Pope Ave- Hagerstown, Md.

17. Burial Date thereof Sept. 9, 1947  
 (Burial, cremation, or removal. Which?)  
 Cemetery or crematory St. Paul's Cemetery

Location Near Hagerstown- Route 40 W.  
 18. Funeral director Fred W. Kraiss  
 Address Hagerstown, Maryland

19. (Date rec'd by registrar) Sept. 9, 1947  
 Registrar

## MEDICAL CERTIFICATION EDT

2D. DATE OF DEATH Sept. 6, 1947 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..., to 19...,

and that I last saw h... alive on 19...

Immediate cause of death

Fractured skull(closed)

Due to Open fracture of left humerus

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9/6/47

Where did injury occur? Hagerstown Wash. Md. (City or town) (State)

Injured at home, farm, industry, public place (where?) Route 40 Deaf Highway

Cause(s) of injury Collision of motorcycle Injured at work? No

Vehicle involved in accident Auto/automobile DEPUTY MEDICAL EXAMINER

Witnesses Parker & Wells WASH. CO., MD.

23. SIGNATURE M. D.

Address Hagerstown, Md. Date signed 9/8/47



PLEASE WRITE PLAINLY, WATCH UNFADING INK. Supply every item of information carefully. Line correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

Dr. Cohen  
08304

## CERTIFICATE OF DEATH

Reg. Date No. 302

250

## 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Hours

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 2 Hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington

City or town Hagerstown R # 2  
(If outside city or town limits, write RURAL and give nearest town)

Street Wilsons  
(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (a) FULL NAME

FRANK LESLIE BLOYER

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male white Married

6.(b) Name of husband or wife Lillie May

7. Birth date of deceased (mo., day, yr.) September 17 1877  
6.(c) If alive, give age 60 years8. AGE: Years Months Days If less than one day  
70 0 8 hrs. min.9. Birthplace Broadfording Wash. Co. Md.  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Retired

12. Name Jacob Bloyer

13. Birthplace Broadfording Md.

14. Maiden name Sophia Neikirk

15. Birthplace Broadfording Md.

16. Informant E. Funk Bloyer

Address Hagerstown Md. R.F.D.

17. Burial Date thereof 9/27/47  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory St/ Pauls Cemetery

Location near Clearspring Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Sept. 27, 47  
(Date rec'd by registrar)Signature Charles Powers  
Registrar

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 25, 1947 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
MDRCN 19 1945 to SEPT. 25 1947  
and that I last saw him alive on SEPT. 25 1947

Immediate cause of death

myocarditis chronic

DURATION

?

Diseases mellitus

?

Doctor cerebral hemorrhage

3 days

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE... Charles Powers  
M. D. of Clear Spring Md  
Address 9/26/47  
Date signed

**RECEIVED**

SEP 30 1947

**BUREAU OF INVESTIGATION**

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Robert Campbell

08305

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Days

Hospital, Institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 10 Days

## 3. (a) FULL NAME

EUGENE EDWIN BROOKMAN

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Gladys

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age 50 year  
October 12, 18828. AGE: Year Monthe Days If less than one day  
65 11 4 hrs. min.9. Birthplace Charlottesville, Va.  
(Town, county, and state)

10. Usual occupation Construction Foreman

11. Industry or business City of Hagerstown

12. Name No Record

13. Birthplace No Record

14. Maiden name No Record

15. Birthplace No Record

16. Informant Mrs Gladys Brookman

Address Hagerstown Md.

17. Burial Date thereof 9/19/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Sept. 18, 47 (Date read by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 289 Frederick St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (b) Social Security Number

214-09-8288

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 16 19 47 at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1946 19 to Sept 19 47

and that I last saw h.i.m. alive on Sept 16 19 47

Immediate cause of death myocardial

failure

Due to arteriosclerosis

Other condition Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

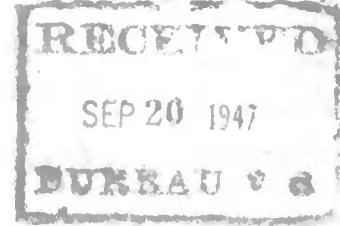
Means of injury Injured at work?

23. SIGNATURE Robert V. h. Campbell

M. D. or other

Address Hagerstown Md. Date signed 9/17/47

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Wells

## CERTIFICATE OF DEATH

94a  
0839602  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

10 mins.

How long in above place of death?

Hospital, Institution, or street address where death occurred:

West Wash. St., Leiter Bros. Store

How long in hospital or institution? none

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Kemp's Mill Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war World War # 1

## 3. (a) FULL NAME

William Allison Burkholder

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

Male White Married

6.(b) Name of husband or wife Elizabeth

7. Birth date of deceased (mo. day. yr.) October 2 1894

6.(c) If alive, give age 50 years

8. AGE: Years Months Days If less than one day 52 11 0 hrs. min.

B. Birthplace Scotland, Franklin Cty., Pa.  
(Town, county, and state)

10. Usual occupation Machinist

11. Industry or business W. M. Rwy. Co.

12. Name William Allison Burkholder

13. Birthplace Scotland, Franklin Cty., Pa.

14. Maiden name Emma Lightner

15. Birthplace Chambersburg, Franklin Cty., Pa.

16. Informant William A. Burkholder, Jr.

Address Hagerstown, Md.

17. Burial Date thereof 9/15/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory National Cemetery

Location Sharpsburg, Md. Hagerstown

18. Funeral director Andrew K. Coffman

Address Hagerstown, Md.

19. Date rec'd by registrar Sept. 4, 47

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Kemp's Mill Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war World War # 1

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION FD7

20. DATE OF DEATH Sept. 2, 1947 11:30 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death coronary occlusion 48hrs DURATION

Due to acute ventricular fibrillation

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Scene of injury Injured at work DEPUTY MEDICAL EXAM.

23. SIGNATURE Robert Wells WASH CO., MD. M. D. *Robert Wells*

Address Hagerstown, Md. Date signed 9/3/47

RECEIVED

SEP 6 1947

BUREAU \* B

1 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08307

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

## 1. PLACE OF DEATH:

County Washington

City or town San Juan

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 years

Hospital, institution, or street address where death occurred:

Fairview Memorial Home

How long in hospital or institution? 47 years

## 3. (a) FULL NAME

Annie F. Cole

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife

John B. Cole

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

January 29 - 1864

8. AGE:

Years 83

Months 7

Days 15

If less than one day

hrs.

min.

9. Birthplace

Auburn Alabama

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

MOTHER FATHER

12. Name Dr. Wm H. Lamar

13. Birthplace Augusta Georgia

Anne Stern

14. Maiden name

Marietta Georgia

15. Birthplace Blanche Lamar Gardner

Address 828 - 18<sup>th</sup> St. N.W. Wash. D.C.

16. Informant Mrs. Blanche Lamar Gardner

Date thereof Sept. 17, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Auburn Cemetery

Location Auburn Alabama

18. Funeral director C.W. J. Best &amp; Sons

Address Boonsboro Md.

19. Sept. 15, 1947 John V. Best

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

no

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH

September 14, 1947, at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 2, 1947, to Sept. 14, 1947, and that last saw her alive on Sept. 13, 1947.

Immediate cause of death

Chronic Myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G.W. Letten M.D.  
Boonsboro  
Date signed 9/15/47  
M. D. opter

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

48a

08308

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County..... Washington  
City or town..... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Life

Hospital, Institution, or street address where death occurred:

111½ West Franklin St.

How long in hospital or institution?

## 3. (a) FULL NAME

Lula M. Colliflower

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married

8.(b) Name of husband or wife..... Albert Ross Colliflower

7. Birth date of deceased (mo., day, yr.)..... May 7, 1886

8.(c) If alive, give age..... years

## 8. AGE:

Years  
61Months  
4Days  
23If less than one day  
..... hrs. ..... min.

9. Birthplace..... Welch Run Penna.

(Town, county, and state)

10. Usual occupation..... Home Duties

## 11. Industry or business

12. Name..... John C. Rummel

13. Birthplace..... Welch Run Penna.

14. Maiden name..... Mary R. Cole

15. Birthplace..... Welch Run Penna.

16. Informant..... Albert Ross Colliflower

Address..... 111½ West Franklin St. Hag.

17. Burial..... Date thereof..... Oct. 3, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rest Haven Cemetery

Location..... Hagerstown, Maryland

18. Funeral director..... Fred W. Kraiss

Address..... Hagerstown, Maryland

19. Date rec'd by registrar..... Oct. 3, 1947  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington  
City or town..... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 111½ West Franklin St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3.(b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 30, 1947 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

14 July 1947, to 30 Sept 1947  
and that I last saw her alive on 30 Sept 1947

Immediate cause of death.....

Cerebral hemorrhage

DURATION

2 days

Due to.....

Due to.....

Other conditions.....

Carcinoma of cervix

6 years

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

Md.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

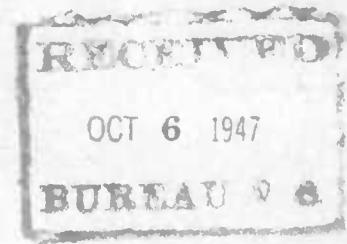
Means of injury.....

Injured at work?

23. SIGNATURE..... Eldon G. Hochlander M.D.

M. D. or other

Address..... Hagerstown, Md. Date signed..... Oct. 4, 1947



## CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 302

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

## 1. PLACE OF BIRTH:

County Washington

City or town Hagerstown, Md.

(If outside city or town limit, write RURAL and give nearest town)

Street address, hospital, or institution:

Washington County Hospital

Length of mother's stay in County 2 1/2 years

(How many years, or months, or days. SPECIFY WHICH)

## 3. Name of child Baby Girl Cramer

## 5. Sex female 6. Twin or triplet

## FATHER OF CHILD

8. Full name Howard Roy Cramer

9. Color white 10. Age at time of this birth 3 3 yrs.

11. Usual occupation Mechanic - Blue Ridge Twp.

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0  
(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 1

17. Did child die before labor? During labor?

18. Pregnancy, complications of

19. Labor: (a) Complications of  
..... (b) Induced?

20. (a) Was there an operation for delivery? (Yes or No)

(b) State all operations, if any

(c) Did child die before operation?  
During operation?23. (a) Burial (b) Date thereof 9-29-47  
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Luther Cemetery

24. (a) Funeral director Scott J. Minnich & Son  
(b) Address Hagerstown, Md.

## 2. USUAL RESIDENCE OF MOTHER:

08309

State Maryland

County Washington

City or town Hagerstown

(If outside city or town limit, write RURAL and give nearest town)

Street No. 210 N. Locust Street

(If RURAL give LOCATION)

## 4. Date of birth September 24 1947 Hour 6:20 A.M.

## 7. No. of weeks pregnancy 26 weeks

## MOTHER OF CHILD

12. Full maiden name Esther Pauline Kramer

13. Color white 14. Age at time of this birth 29 yrs.

15. Usual occupation housewife

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes prematurity

(b) Maternal causes

22. I certify to the birth of this child who was born dead\* on the date and hour above stated.

Signature Dr. Charles E. Klemm, M.D.

(Specify if M. D., midwife, or other)

Address Hagerstown, Md.

25. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date rec'd by registrar) (Registrar)26. (To be filled out if no physician was present at delivery.)  
The above certificate has been examined by me.

Health Officer, per

RECEIVED

SEP 26 1947

BUREAU F B I

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08310

50

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
County Washington  
City or town Mapleville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death 14 days

Hospital, institution, or street address where death occurred:

Main St.

How long in hospital or institution? at Home

## 3. (a) FULL NAME

Gertrude Anna Florence Cunningham

## 3. (b) Social Security Number

None

4. Sex Female Color or race White Marital status Married

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife William Cunningham

7. Birth date of deceased (mo., day, yr.) June - 19 - 1879

6. (c) If alive, give age years

8. AGE: Years 68 Months 2 Days 20 If less than one day hrs. min.

9. Birthplace Near Bovisboro Wash Co. Md. (Town, county, and state)

10. Usual occupation House Wife

11. Industry or business Open Home

12. Name John Gante

13. Birthplace Fred. Co. Md.

14. Maiden name Maryella Smith

15. Birthplace Fred. Co. Md.

16. Informant Mrs. Elmer Gross

Address Mapleville Md.

17. Burial Date thereof Sept. 12, 1947  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Fairview Cemetery

Location near Mapleville Md.

18. Funeral director E.W. J. Best &amp; Sons

Address Bovisboro Md.

19. Sept. 12, 1947 John H. Best  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Mapleville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war No.

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 9<sup>th</sup> 1947 at 4:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3<sup>rd</sup> 1947 to Sept. 1947 and that I last saw her alive on Sept. 6<sup>th</sup> 1947

Immediate cause of death

Proximate cause of Death 2 yrs. 5 mos.

Due to Arterial Hypertension 2 yrs. 5 mos.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John H. Best M.D.

M. D. or other

Address Bovisboro Md. Date signed 9/10/47

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SEP 16 1947

BUREAU \* S

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

486 X

08311

302

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Rural Hagerstown, Md. R D 4  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 12 years

Hospital, Institution, or street address where death occurred:

Carfoss Dist.

How long in hospital or institution?.....

## 3. (a) FULL NAME

Lilly May Ditto

## 4. Sex

## 5. Color or race

## 6.(a) Single, married, widowed, or divorced

Female

White

Widowed

Milton O. Ditto

## 6.(b) Name of husband or wife

6.(c) If alive, give age..... years

## 7. Birth date of deceased (mo., day, yr.)

Aug. 29, 1866

## 8. AGE:

Years 81

Months 0

Days 6

If less than one day hrs. min.

## 9. Birthplace

Washington County, Md.

(Town, county, and state)

## 10. Usual occupation

Home Duties

## 11. Industry or business

12. Name..... David Pittinger

13. Birthplace Wash. Co., Md.

14. Maiden name Mary Spickler

15. Birthplace Wash. Co., Md.

16. Informant Mrs. Harry Pittinger

Address Hagerstown, Md. R D 4

17. Burial Date thereof..... Sept. 7, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Paul's Cemetery

Location..... Near Hagerstown Route 40 W

18. Funeral director..... Fred W. Kraiss

Address Hagerstown, Md.

19. Date rec'd by registrar..... Sept. 7, 1947

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington

City or town..... Rural Hagerstown R D 4

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Carfoss Dist.

(If rural, give LOCATION)

## 2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 4, 1947 19. 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10/1/45 to 1947, and that I last saw her alive on 8/1/30 1947

Immediate cause of death.....

Cerebral hemorrhage

DURATION

1 yr.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... None

Date of op. ....

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE.....

M. D. or other

Address..... Greenfield, 18 Date signed..... 2/6/47



PLEASE WRITE PLAINLY, USE UNFADED INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08312

94a

## CERTIFICATE OF DEATH

Reg. Distr. No. ....

302

## 1. PLACE OF DEATH:

County ..... Washington

City or town ..... Hagerstown, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ..... 10 years

Hospital, institution, or street address where death occurred:

49 Summit Avenue

How long in hospital or institution? .....

## 3. (a) FULL NAME

John D. Fleming

## 4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Single

## 8.(b) Name of husband or wife.....

6.(c) If alive, give age ..... years

## 7. Birth date of deceased (mo., day, yr.)

October 18, 1910

## 8. AGE:

Years	Months	Days	If less than one day		
36	11	17	hrs.	min.	

## 9. Birthplace.....

Harrisburg, Pa.

(Town, county, and state)

## 10. Usual occupation.....

Laborer

## 11. Industry or business

12. Name..... Grant Fleming

13. Birthplace..... Gettysburg, Pa.

14. Maiden name..... Mabel J. Baxter

15. Birthplace..... Harrisburg, Pa.

16. Informant..... Melvin Fleming

Address..... Hagerstown, Maryland

17. Burial..... Date thereof..... 9-6-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rest Haven Cemetery

Location..... Hagerstown, Maryland

18. Funeral director..... C. M. Suter &amp; Sons

Address..... Hagerstown, Maryland

19. Signature..... Sept. 6, 47

(Date rec'd by registrar) 19

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington

City or town..... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 49 Street Name..... Summit Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war..... World War II

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

ED

20. DATE OF DEATH..... Sept. 4, 1947, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death.....

Acute coronary occlusion

DURATION

15 hrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... None

Date of op.....

Autopsy results..... As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... No.

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE..... Robert Mulls

DEPUTY MEDICAL EXAM.  
WASH. CO., MD.  
M. D. or other

Address..... Hagerstown, Md.

Date signed..... 9/5/47

RECEIVED

SEP 9 1947

BUREAU OF

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08313

159

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Washington t

City or town..... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 hours

Hospital, institution, or street address where death occurred: Wm. C. Army

How long in hospital or institution? 16 hours

## 3. (a) FULL NAME

Martha Irene Francis

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1947

8. AGE: Years      Months      Days      If less than one day  
16 hrs. min.

9. Birthplace..... Maryland (town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER	12. Name..... Russell Francis
	13. Birthplace.....

MOTHER	14. Maiden name..... Ethel Miller
	15. Birthplace.....

16. Informant.....

Address.....

17. Burial..... Date thereof..... 9/16/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Mays Chapel Cemetery  
Location..... Hancock18. Funeral director..... Snyder and Rowland  
Address..... Hancock, Maryland

19. (Date rec'd by registrar) 19..... Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington

City or town..... Hancock

(If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 12 19... 47, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Sept. 11, 1947, to Sept. 12, 1947, and that I last saw her alive on Sept. 12, 1947.

Immediate cause of death..... D. Tuberousis

DURATION.....

Due to..... Frenatitis

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

\*\* Signature of physician M. D. or other

Address..... Date signed..... 11/04/47



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully and clearly. It is especially important. Physicians: please write the causes of death clearly and briefly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

## CERTIFICATE OF DEATH

08364

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Washington

City or town..... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?.....

## 3. (a) FULL NAME

Edgar Lewis Golden

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Single

## 6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1947

## 6.(c) If alive, give age..... years

## 8. AGE:

--

Years

Months

Days

1

If less than one day

hrs. ..... min.

## 9. Birthplace..... Hagerstown- Washington- Md..

(Town, county, and state)

## 10. Usual occupation..... None- Infant

## 11. Industry or business

John Richard Golden

12. Name

13. Birthplace

Ethel L. Golden

Wash. Co. Md.

## 14. Maiden name..... Ethel L. Golden

## 15. Birthplace..... Washington County, Md.

Ethel L. Golden

Address 336 Mitchell Ave- Hagerstown, Md.

## 17. Burial..... Date thereof..... Sept. 20-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Fahrney's Cemetery

Location..... Mapleville, Md.

## 18. Funeral director..... Fred W. Kraiss

Address..... Hagerstown, Md.

Sept. 20, 1947 (Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County Washington

City or town..... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 336 Mitchell Avenue

(If rural, give LOCATION)

## 2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 19, 1947 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h..... alive on 19..... to 19.....

Immediate cause of death.....

Due to..... Atelectasis

(Premature birth 7 Mo.)

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

no

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... no

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

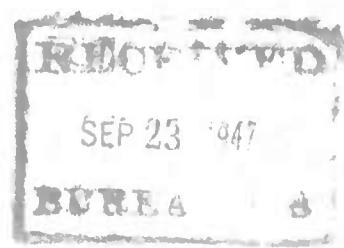
Means of Injury

Injured at work?

23. SIGNATURE

M. D. or

Address..... Hagerstown, Md. Date signed 9/20/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

59

## CERTIFICATE OF DEATH

83a 08315 304  
Reg. Dist. No.

1. PLACE OF DEATH: Washington  
 County.....  
 City or town..... Pectonville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Five months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Lucinda Graham

4. Sex <b>female</b>	5. Color or race <b>white</b>	6.(a) Single, married, widowed, or divorced <b>widowed</b>
-------------------------	----------------------------------	---

6.(b) Name of husband or wife..... Thomas Graham

7. Birth date of deceased (mo., day, yr.)..... February 4, 1871

6.(c) If alive, give age..... years

8. AGE: Years  
76 Months  
7 Days  
26 If less than one day  
..... hrs. ..... min.9. Birthplace..... Washington Co., Md.  
(Town, county, and state)  
Home duties

10. Usual occupation.....

11. Industry or business.....

12. Name.....	Samuel Hastings
13. Birthplace.....	Wash. Co. Md.

14. Maiden name.....	Jennie Bridendolph
15. Birthplace.....	Wash. Co. Md.

16. Informant..... Miss Minerva Hastings  
Address..... Pectonville, Md.17. Burial..... Date thereof..... Oct. 3, 1947  
(Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)Cemetery or crematory..... Cemetery  
Location..... Mercersburg, Pa.18. Funeral director..... Snyder-Rowland  
Address..... Hancock, Md.19. (Date rec'd by registrar)..... 10-2-47  
(Date rec'd by registrar)..... 19.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
**Maryland**

State..... County..... Washington

City or town..... Pectonville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 30, 1947, at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 19, 1947, to Sept. 30, 1947, and that I last saw her alive on Sept. 23, 1947.

Immediate cause of death.....

Cerebral Hemorrhage Sudden

Due to..... Arterial Sclerosis 8 yrs.

Due to..... Other conditions Arterial Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

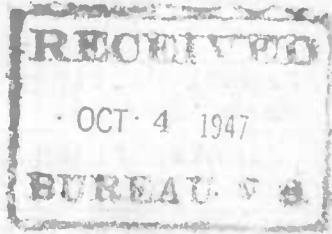
Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... David P. Brewer M.D. M. D. or other

Address..... Clear Spring Md. Date signed 10/1/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Ditto

08316

131a

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Days

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 6 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Clearspring R#1

(If outside city or town limits, write RURAL and give nearest town)

Street No. St. Pauls

(If rural, give LOCATION) A.S.N. 24384

2.(a) If veteran, name war Spanish American War

## 3. (a) FULL NAME

HARRY HAMBY SR.

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife Susie Bingaman Hamby

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo. day, yr.) November 14, 1881

8. AGE: Years Months Days It less than one day  
65 9 29 hrs. min.9. Birthplace Chewsville, Washington Co. Md.  
(Town, County, and state)

10. Usual occupation Farmer

11. Industry or business Retired

MOTHER FATHER 12. Name James M. Hamby

13. Birthplace Chewsville Md.

14. Maiden name Mary Robison

15. Birthplace Chewsville Md.

16. Informant Mrs. Susie B. Hamby

Address Hagerstown R#2 Md.

17. Burial Date thereof 9/16/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Dunkard Cemetery

Location Broadfording Md.

18. Funeral director Andrew K. Coffman

Address Hagers town Md.

19. Sept. 16. 47 Sheriff Powers  
(Date rec'd by registrar)

Registrar

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 13 1947 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 15-47 until Sept 15 1947

and that I last saw him alive on Sept 15 1947

Immediate cause of death

Ch. Nephritis

Due to Paroxysmal Cerebral

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

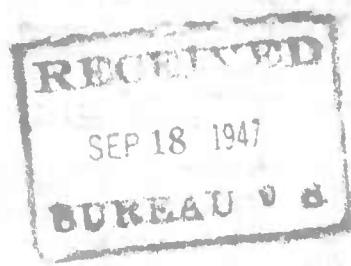
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. W. Coffman

M. D. or other

Address Requested by Date signed



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

58

08317

## CERTIFICATE OF DEATH

Reg. Dist. No. 304

~~Please write plainly, with unfading ink. Supply every item of information carefully. Use correct age.~~  
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age.  
 is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County Washington

City or town Hancock

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Charles Edgar Henry

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Mary Burgess Henry

6. (c) If alive, give age 65 years

7. Birth date of deceased (mo. day, yr.)

Aug. 31 1881

8. AGE:

Years

Months

Days

If less than one day

66 0 23

— hrs. —

min.

9. Birthplace

Hancock, Wash Co., Md.

(Town, county, and state)

10. Usual occupation B+O Telegraph Operator

## 11. Industry or business

Charles David Henry

MOTHER FATHER

12. Name

Charles David Henry

13. Birthplace

Morgan Co., W. Va.

14. Maiden name

Mary Elizabeth Michael

15. Birthplace

Morgan Co., W. Va.

16. Informant

John Henry

Address

2011 Littitia Ave., Balto., Md.

17. Burial

Date thereof Sept. 26, 1947  
(Burial, cremation, or removal. Which?)

(Month) (day) (year)

Cemetery or crematory

St. Thomas Episcopal

Location

Hancock, Md.

18. Funeral director

Charles R. Best

Address

Hancock, Md.

19. Date rec'd by registrar

9/26/47

J. A. Steller

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Washington

City or town Hancock

(If outside city or town limits, write RURAL and give nearest town)

Street No. East Main St.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

705-05-8020

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23

1947 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Sept. 23, 1947

19.

Immediate cause of death

Cardiac Arrest

DURATION

Unmeasured

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

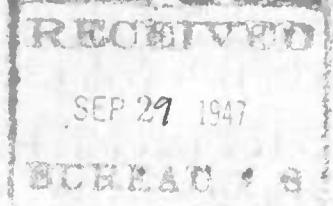
Means of injury

Injured at work?

23. SIGNATURE

H. H. Baker, M.D. M. D. or other

Hancock, Md. Date signed 9/26/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08318

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH: Washington  
County.....  
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution or street address where death occurred:

Gale Way Nursing Home  
10 days

How long in hospital or institution?

3. (a) FULL NAME

EMMA MYERS HOFFMAN

3. (b) Social Security Number

None

4. Sex F 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Emanuel Hoffmann

6.(c) If alive, give age dead years

7. Birth date of deceased (mo., day, yr.) Oct. 12. 1863

8. AGE: 83 Years 10 Months 20 Days If less than one day  
hrs. min.

9. Birthplace Wish Run Pa  
(Town, county, and state)

10. Usual occupation House Keeper

11. Industry or business Home

12. Name John Myers

13. Birthplace Berlin

14. Maiden name Maria Hawbaker

15. Birthplace Pa

16. Informant Charles W. Hoffmann

Address Greencastle Pa

17. B (Burial, cremation, or removal, which?) Date thereof Sept 5 47  
(month) (day) (year)

Cemetery or crematory Greenview

Location Williamsport Md

18. Funeral director R. B. Munner

Address Greencastle Pa

19. Sept 3 1947 (Date rec'd by registrar) 20. Sept 11 1947 (Date of death) 21. Sept 11 1947 (Date signed)  
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pa County Franklin

City or town Greencastle Pa  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 414 E. Baltimore St  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10/11/1946 to 9/12/1947

and that I last saw her alive on 9/11/1947

Immediate cause of death Arteriosclerotic

Cardio-vascular - renal disease

DURATION

15 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations None done

Date of op. Sept 11 1947

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE McBryde

M. D. or other

Address Greencastle Pa Date signed Sept 11 1947

RECEIVED

SEP 19 1947

BUREAU OF INVESTIGATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Ditto

68319

1248

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 12 Hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 135 McComas St.

(If rural, give LOCATION)

2.(a) If veteran, name war... None

## 3.(a) FULL NAME

Raymond Wingert Hoover

## 4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

## 6.(b) Name of husband or wife

Lottie May Hoover

6.(c) If alive, give age 51 years

## 7. Birth date of deceased (mo. day, yr.)

August 9, 1891

## 8. AGE:

Years

Months

Days

If less than one day

56

1

19

hrs.

min.

## 9. Birthplace

Mowersville, Cumberland Co., Pa.

(Town, county, and state)

## 10. Usual occupation

Machinist

## 11. Industry or business

Brandt Cabinet works

## MOTHER FATHER

Samuel Hoover

## 13. Birthplace

Mowersville Pa.

## 14. Maiden name

Barbara Bricker

## 15. Birthplace

Mowersville Pa.

## 16. Informant

Mrs. Lottie May Hoover

## Address

Hagerstown Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 9/30/47

(month) (day) (year)

## Cemetery or crematory

Spring Hill Cemetery

## Location

Shippensburg Pa.

## 18. Funeral director

Andrew K. Coffman

## Address

Hagerstown Md.

## 19. (Date rec'd by registrar)

Sept. 29, 47

Registrar

Registrar

23. SIGNATURE

M. D. or other

Address Date signed

Dr. Ditto

Hagerstown Md.

Sept. 29, 47

253

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1947 at 4:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Sept 27-47 1947

Immediate cause of death

Cardiac failure

DURATION

6 yrs

Due to

Ch. nephritis

1 yr

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Address

Date signed



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08320

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington, Md.  
City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

50 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

515 Brown Avenue

How long in hospital or institution?

## 3. (a) FULL NAME

Lydia Ann Huyett

## 4. Sex

Female White

## 5. Color or race

Widow

## 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Huron A. Huyett

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, y.)

March 26, 1851

## 8. AGE:

Years 96

Months 5

Days 15

If less than one day

hrs.

min.

9. Birthplace Washington County, Md.

(Town, county, and state)

## 10. Usual occupation

Home Duties

## 11. Industry or business

12. Name Abram Shupp

13. Birthplace Wash. Co., Md.

14. Maiden name Ann Smith

15. Birthplace Wash. Co. Md.

16. Informant Eva L. Huyett

Address 515 Brown Ave- Hagerstown, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept. 13-47  
(month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Sept. 12, 47 *Chastin Flowers*  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 515 Brown Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

Sept. 10, 1947 11:55 A. M. M.

2D. DATE OF DEATH

I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-1-45- to 9-10-47

and that I last saw deceased alive on 9-5-47

Immediate cause of death

Due to *Senility*Due to *Ch. Myocarditis*

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

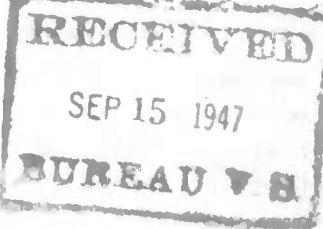
Injured at work?

23. SIGNATURE

*W. H. Huyett*

M. D. or other

Address *Hagerstown, Md.* Date signed *Sept. 12, 1947*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08321

242

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington  
 County.....  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 35 years  
 Hospital, institution, or street address where death occurred: Washington County Hospital  
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Md. County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 551 Jefferson St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME  
 Nellie L. Kline

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife..... Scott M. Kline  
 7. Birth date of deceased (mo., day, yr.) ..... 6.(c) If alive, give age 46 years  
 February 16, 1912

8. AGE: Years 35 Months 6 Days 18 If less than one day . hrs. . min.

9. Birthplace..... Hagerstown, Wash. Co., Md.  
 (Town, county, and state)

10. Usual occupation..... Weaver

11. Industry or business..... Cromer's Silk Mill

FATHER 12. Name..... Harvey L. Smith

MOTHER 13. Birthplace..... Hagerstown, Md.

14. Maiden name..... Minnie Mae Strock

15. Birthplace..... Hagerstown, Md.

16. Informant..... Scott M. Kline, Jr.

Address..... Hagerstown, Md.

17. Burial..... Date thereof. Sept. 17 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill Cemetery

Location..... Hagerstown, Md.

18. Funeral director..... Scott F. Minnich & Son

Address..... Hagerstown, Md.

19. (Date rec'd by registrar) Sept. 16, 1947 by J. W. I. Powers  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 14, 1947 at 7:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 30 1947 to Sept. 14 1947 and that I last saw her alive on Sept. 14 1947

Immediate cause of death..... UNDETERMINED

Due to..... ACUTE FEBRILE  
 ILLNESS OF UNKNOWN CAUSE

Due to.....

Other conditions..... ① BRONCHIAL PNEUMONIA ② D.P.N.S.  
 ③ PSYCHOSIS

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... BRONCHIAL PNEUMONIA LEFT

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

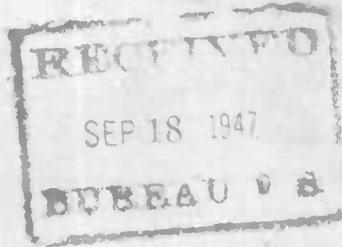
Means of injury..... Injured at work?

23. SIGNATURE..... J. W. I. Powers, M.D.

M. D. or other

Address..... 100 Parkman Court, Bel Air, Md.

Date signed..... Sept. 15, 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08322 237

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County.....

City or town.....

Washington

Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 days

Hospital, institution, or street address where death occurred:

Washington Co Hospital

How long in hospital or institution?

7 days

## 3. (a) FULL NAME

TRUMAN S. KUHN

4. Sex

M. W. Widowed

5. Color or race

8.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

Emma M. Kuhn

7. Birth date of deceased (mo., day, yr.)

MAR 25, 1868

6.(c) If alive, give age

dead

years

8. AGE:

79 Years 5 Months 15 Days

If less than one day

hrs. min.

9. Birthplace

St Thomas Pa.

(Town, county, and state)

10. Usual occupation.

Farmer

11. Industry or business

Retired

12. Name

Jacob B. Kuhn

Penns

13. Birthplace

Penns

Kathryn Leiter

14. Maiden name

Penns

Geo Kuhn

16. Informant

Kauffman Station Pa

17. (Burial, cremation, or removal, Which?)

B Date thereof Sept 13/47

(month)

(day)

(year)

Cemetery or crematory

Salem Cemetery

Location

near Marion Pa

18. Funeral director

A E Minich

Address

Green Castle Pa

Sept. 12, 1947 Glass Powers

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Pa

County.....

Franklin

City or town.....

Chamberlain R.D. 6

Street No.....

Kauffman Station

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

Sept 10 1947 at 5<sup>30</sup>

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/1 1939 to 9/10 1947

and that I last saw him alive on 9/10 1947

Immediate cause of death Chronic rheumatic heart disease &amp; congestive failure

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

not done

Date of op.

Autopsy results

not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

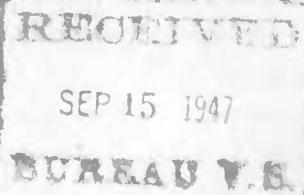
injured at work?

23. SIGNATURE

W. H. Kuhn M.D.

or other

Free month of Sept 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Yeager 254

08323

302

Reg. Dist. No. 302

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

1. PLACE OF DEATH:  
 County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Weeks

Hospital, Institution, or street address where death occurred: Washington County Hospital

How long in hospital or institution? 3 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn Infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1249 Potowmack Ave.  
 (If rural, give LOCATION)

2.(a) Is veteran, name war? None

3. (a) FULL NAME  
 DR. AUGUSTUS CARL MAISCH

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife Elda T.

7. Birth date of deceased (mo., day, yr.) July 1, 1872

8. AGE: Years Months Days If less than one day  
 75 2 27 hrs. min.

9. Birthplace Philadelphia, Philadelphia Co., Pa.  
 (Town, county, and state)

10. Usual occupation Doctor

11. Industry or business Oculist

MOTHER FATHER 12. Name John M. Maisch

13. Birthplace Germany

14. Maiden name Charlotte J. Kuhl

15. Birthplace Germany

16. Informant Mrs Elda T. Maisch

Address Hagerstown Md.

17. Burial Date thereof 9/30/47  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Sept. 29, 1947 Death record  
 (Date rec'd by registrar)

Registrar

3. (b) Social Security Number  
 None

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 28, 1947, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 22, 1947, to Sept. 28, 1947, and that I last saw him alive on Sept. 28, 1947.

Immediate cause of death  
 Cerebral Vasculitis Disease  
 Due to Chronic Pul. Tuberculosis

Due to  
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations  
 Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide X Date of X

Where did injury occur? (City or town) X (County) X (State) X

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Howard Yeager  
 Address Hagerstown, Md. M. D. or other  
 Date signed Sept. 29, 1947

RECEIVED

OCT 1 1947

BURBAD L.L.C.

RECEIVED

-- 1 1947

RECEIVED

I

PLEASE WRITE PLAINLY,  
WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08324

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Died enroute to hospital

Hospital, Institution, or street address where death occurred:

Virginia Avenue

How long in hospital or institution? Dead on admittance

## 3. (a) FULL NAME

David Thomas Lasher Malott

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife Emma Virginia Malott 47  
.....(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1894

8. AGE: Years Months Days It less than one day  
52 9 12 hrs. min.9. Birthplace Williamsport, Washington, Maryland  
(Town, county, and state)

10. Usual occupation Truck operator

11. Industry or business Hauling and Transfer &amp; Ice

12. Named Father James Elias Malott  
13. Birthplace Williamsport, Maryland14. Maiden name Emma Maddox Knodle  
15. Birthplace Near Tilghmanton, Maryland16. Informant Mrs. Emma V. Malott  
Address Route # 1 Williamsport, Maryland17. Burial Date thereof Sept. 7, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Greenlawn CemeteryLocation Williamsport, Maryland  
18. Funeral director Mrs. Edith V. Leaf

Address Williamsport, Maryland.

19. (Date rec'd by registrar) Sept. 6, 1947  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Williamsport (RURAL)  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Greencastle Pike

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number None

## MEDICAL CERTIFICATION

D.S.T.

20. DATE OF DEATH SEPTEMBER 5 1947 at 8:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
February 2 1946 to SEPT. 5 1947

and that I last saw h. : m alive on JULY 18 1947

Immediate cause of death

CORONARY OCCLUSION

DURATION

1 min.

Due to CHRONIC MYOCARDITIS?

Due to

Other conditions

None.

(Include pregnancy within 3 months of death)

Major findings of operations

None.

Date of op. 1947

Autopsy results

None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

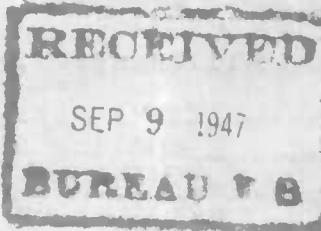
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Auela Robert Cohen  
clear Spring Ind M. D. 9-5-47  
Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death clearly and legibly.  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08325

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

93d

## 1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? One day

## 3. (a) FULL NAME

Maude A. McCoy

4. Sex 5. Color or race 8.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife Merrit M. McCoy

7. Birth date of deceased (mo. day, yr.) May 17, 1881 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day  
66 4 12 hrs. min.9. Birthplace Bedford, Pa.  
(Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

12. Name Not Known

13. Birthplace

14. Maiden name Not Known

15. Birthplace

16. Informant Mrs. Daniel Meyers

Address Hagerstown, Maryland

17. Burial Date thereof 10-2-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter &amp; Sons

Address Hagerstown, Maryland

19. Oct 1. 1947 Death Powers  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 120 East Antietam Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Sept 29, 1947 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1942 to Sept 29, 1947

and that I last saw her alive on Sept 29, 1947

Immediate cause of death

Heart Block -  
Duration 1 dayDue to Hypertension Heart Disease  
Duration 4 yrs?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Hagerstown Md. M. D. or other

Address Date signed 10/1/47-

RECEIVED

OCT 3 1947

BERKSHIRE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08326

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

## 1. PLACE OF DEATH:

County Washington

City or town Rural Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

Wilsons Route 40 W

How long in hospital or institution? 3 Months

## 3. (a) FULL NAME

Temma Moser

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

Female White

Widow

## 6. (b) Name of husband or wife

Elmer C. Moser

## 7. Birth date of deceased (mo., day, yr.)

October 3, 1867

## 6. (c) If alive, give age

years

## 8. AGE:

Years 79

Months 11

Days 18

## If less than one day

hrs.

min.

## 9. Birthplace Myersville - Fredk. Co., Md.

(Town, county, and state)

## 10. Usual occupation

Home Duties

## 11. Industry or business

## 12. Name

Aaron Poffenberger

## 13. Birthplace

Frederick Co., Md.

## 14. Maiden name

Caroline Marteny

## 15. Birthplace

Frederick County, Md.

## 16. Informant

Mrs. C. Ray Ford,

## Address

311 Summit Ave. Hagerstown, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept. 24 1947

(month) (day) (year)

## Cemetery or crematory

Rest Haven

## Location

Hagerstown, Md.

## 18. Funeral director

Fred W. Kraiss

## Address

Hagerstown, Md.

Sept. 23 1947  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 311 Summit Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

Sept. 20, 1947 7:30 P.

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above-stated; that I attended deceased from June 1 - 1945 to Sept. 20 - 1947 and that I last saw her alive on Sept. 20 - 1947

Immediate cause of death

Cardio - Vascular Disease

DURATION

6 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John W. Finkler  
Hagerstown, Md. Date signed Sept. 23, 1947  
Address

M. D. or other







## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08328

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
 County Washington  
 City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Two weeks

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? Two weeks

## 3. (a) FULL NAME

Charles Thomas Palmer

4. Sex Male	5. Color or race White	6.(a) Single, married, widowed, or divorced Married
-------------	------------------------	---

6.(b) Name of husband or wife Anna Belle Palmer

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1884

6.(c) If alive, give age 70 yrs. years

8. AGE: Years Months Days If less than one day

63 6 19 hrs. min.

9. Birthplace Williamsport, Washington, Maryland

(Town, county, and state)

10. Usual occupation Leather Finisher

11. Industry or business Leather Tannery

12. Name Father Nathan Palmer

13. Birthplace Virginia

14. Maiden name Frances Elizabeth Howard

15. Birthplace Near Williamsport, Maryland

16. Informant Anna Belle Palmer

Address Williamsport, Maryland

Burial

17. Date thereof Sept. 14, 1947

(Burial, cremation, or removal. Which?)

Cemetery or crematory Riverview Cemetery

Location Williamsport, Maryland

18. Funeral director Mrs. Edith V. Leaf

Address Williamsport, Maryland

19. Date rec'd by registrar Sept. 14, 1947

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Williamsport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 42 West Salisbury Street

None

2.(a) If veteran, name war.

## 3. (b) Social Security Number

219-05-2199

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 11 1947 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 28 1947 to Sept. 11 1947

and that I last saw him alive on Sept. 11 1947

Immediate cause of death

Tonsillectomy

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

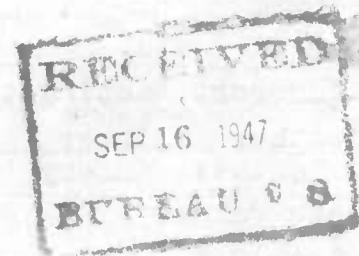
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address William Street M.D. Date signed 9/15/47



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08329

93d  
Reg. Dist. No. 307

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

Washington

County

Trego

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mary Elizabeth Pike

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife Edgar B. Pike

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby. 21, 1880

8. AGE:

Years  
67Months  
7Days  
1If less than one day  
.....hrs. ....min.9. Birthplace Washington County, Md.  
(Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

12. Name Daniel Drury

13. Birthplace Franklin Co., Pa.

14. Maiden name Susan H. Wilson

15. Birthplace Franklin Co., Pa.

16. Informant Mrs. Merle Clipp

Address Trego, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept. 25 1947  
(month) (day) (year)

Cemetery or crematory Broadfording Cemetery

Location Near Cearfoss, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Sept. 25, 1947 Mrs. Katherine Dugay  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Trego  
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1947 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 7, 1947, to Sep. 22, 1947,

and that I last saw her alive on September 21, 1947.

Immediate cause of death

Broncho-pneumonia

DURATION

3 days

Due to Chronic hepatitis and  
chronic cholangitis

5 years

Due to

Other conditions Arterio-sclerotic  
heart disease  
(Include pregnancy within 3 months of death)

5 years

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

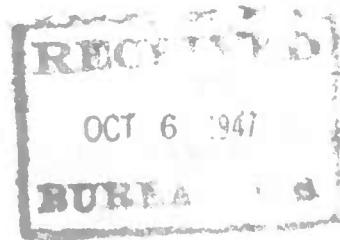
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Henry Aldis M.D.  
M. D. or other  
Address Shepherdstown, W. Va. Date signed 9/24/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

8413

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

170C

1. PLACE OF DEATH: Washington  
 County.....  
 City or town..... Magerstowt  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? One day  
 Hospital, institution, or street address where death occurred: Washington Co. Hospital  
 How long in hospital or institution? One day

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 Maryland Washington  
 State.....  
 City or town..... Pectonville, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 Rural give LOCATION  
 2.(a) If veteran, name war. World War Two

3.(a) FULL NAME Wallace Wilbur Reed

3.(b) Social Security Number 219-12-0873

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife.....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 24, 1921

8. AGE:	Years 26	Months 3	Days 18	If less than one day hrs. .... min.
---------	-------------	-------------	------------	--

9. Birthplace Williamsport, Md.

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Daniel Elwood Reed

MOTHER FATHER 13. Birthplace Maryland

14. Maiden name mary m. Mills

15. Birthplace Park Head, Md.

16. Informant Mrs. Mary M. Mills

Address Pectonville, Md.

17. Burial Burial Date thereof Sept. 14, 1947  
 (Burial, cremation, or removal. Which?) Date (month) (day) (year)

Cemetery or crematory Cemetery

Location Park Head, Md.

18. Funeral director Snyder-Rowland

Address Hancock, Md.

19. Sept. 13, 1947 ShaftBowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

E.D.T. P.

20. DATE OF DEATH Sept. 11, 1947 19..... at 11:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death.....

Open fracture of left humerus

Due to..... exsanguination & shock

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. None

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9/11/47

Where did injury occur? 61/2 mi. west Magerstowt, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where) 61/2 mi. West Mager-

Means of Injury Auto - collidied with Coal truck (Cause of death) Injured at work? No

DEPUTY MEDICAL EXAMINER Robert Wells WASH CO. MD.

M. D.

23. SIGNATURE Robert Wells WASH CO. MD.

Address..... Hagerstown, Md. Date signed 9/13/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08330

302

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

Washington

City or town.....

Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

2 years

Hospital, institution, or street address where death occurred:

252 Frederick Street

How long in hospital or institution?.....

at Home

## 3. (a) FULL NAME

Samuel E. Reeder

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Annie Reeder

7. Birth date of deceased (mo., day, yr.)

January - 15 - 1867

8. AGE:

Years

Months

Days

If less than one day

80

8

0

hrs.

min.

9. Birthplace.....  
(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

Retired

MOTHER FATHER

12. Name..... Andrew Reeder

13. Birthplace..... Wash. Co. Md.

14. Maiden name..... Ruthette Boyer

15. Birthplace..... Wash. Co. Md.

16. Informant..... Mrs. E. C. Henninger

Address..... 252 Frederick St. Hagerstown Md.

17. Burial..... Burial

Date thereof..... Sept. 18. 1947  
(month) (day) (year)

Cemetery or crematory..... Locust Grove Cemetery

Location..... Locust Grove Wash. Co. Md.

18. Funeral director..... Elvin J. Best &amp; Sons

Address..... Baltimore Md.

19. Date rec'd by registrar..... Sept. 17. 1947

Signature..... Elvin J. Best &amp; Sons

Registrar.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

Washington

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 252 - Frederick Street

(If rural, give LOCATION)

2.(a) If veteran, name war..... no.

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... September - 15 - 1947, at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July - 12 1947 to Sept. 15 1947

and that I last saw him alive on September 14 1947

Immediate cause of death.....

Exsanguination of lungs

DURATION

2 days.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

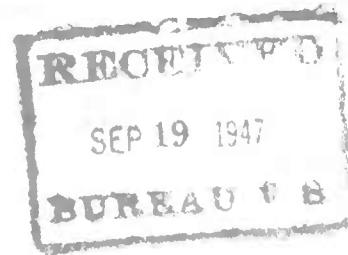
Injured at work?

23. SIGNATURE..... Elvin J. Best &amp; Sons

M. D. or other

Address..... Baltimore Md.

Date signed..... Sept. 16/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

08331

240

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:  
County Washington

City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:  
Wash Co. Hospital

How long in hospital or institution?

3. (a) FULL NAME  
Fredrick A. Risling

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Ida M. Risling

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1874

8. AGE: Years Months Days If less than one day  
73 - - hrs. min.

9. Birthplace Bedford County, Pa.  
(Town, county, and state)

10. Usual occupation Store Employee

11. Industry or business Grocery

MOTHER FATHER  
12. Name Joseph Risling  
13. Birthplace Bedford Co., Pa.

14. Maiden name Jennie Hoffman

15. Birthplace Bedford Co., Pa.

16. Informant Mrs. Baxter Nunamaker

Address 113 N. Locust St/ Hagerstown, Md.

17. Burial Date thereof Sept. 14, 1947  
(Burial, cremation, or removal. Which?)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Sept. 13, 1947  
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 113 North Locust St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1947 12:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/1/47 19 to 9/12/47 19  
and that I last saw him alive on 9/12/47 19

Immediate cause of death

Gangrene Heart Failure 1 mo.

DURATION

Due to

Due to

Other condition

Gastritis 3 left upper lobe (Lung) 2 mos

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Hagerstown, Md. Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age.  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08332

93d

## CERTIFICATE OF DEATH

Reg. Dist. No.

363

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Rural - Clearspring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, Institution, or street address where death occurred:

Gateway Nursing HomeHow long in hospital or institution? 2 weeks

## 3. (a) FULL NAME

Ira G. Robinson

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Married6.(b) Name of husband or wife Mary E. MentzerROBINSON6.(c) If alive, give age 65 years

7. Birth date of deceased (mo. day, yr.)

April 15, 1878

8. AGE:

Tears  
69Months  
5Days  
1If less than one day  
— hrs. — min.9. Birthplace Wheatland Mercer, Penna.

(Town, County, and state)

10. Usual occupation Contractor - State Roads Builder

## 11. Industry or business

MOTHER FATHER John Robinson13. Birthplace Penna.14. Maiden name Amanda Gould15. Birthplace Penna.16. Informant Mrs. Mary E. RobinsonAddress Hancock, Md.17. Burial Burial Date thereof Sept 9, 1947  
(Burial, cremation, or removal. Which?)Cemetery or crematory Geeseytown CemeteryLocation Geeseytown, Blair Co., Penna.18. Funeral director Charles R. BaslAddress Hancock, Md.19. Sept 1947 Leroy W. Forkler  
(Date rec'd by registrar) Deputy Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hancock (If outside city or town limits, write RURAL and give nearest town)Street No. Main Street (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6, 1947 at 9 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 5, 1947, to Sept 6, 1947and that I last saw him alive on Sept 5, 1947.

Immediate cause of death

Cerebral hemorrhage, right  
c. hemiplegiaDue to Generalized arterio-sclerosis

DURATION

10 mos.  
years

Due to

Other conditions Urinary tract infection  
Arterio-sclerotic heart disease  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

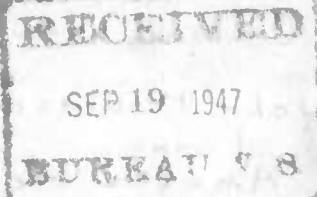
Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

R. L. Hauffer, M.D.  
 M. D. or other  
 Address Hagerstown, Md. Date signed Sept 6, 1947



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08333

## CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH: Washington  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
1 day  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Washington County Hospital  
1 day  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Washington  
City or town..... Keedysville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)

3. (a) FULL NAME Charlotte G. Rohrer

3. (b) Social Security Number  
None

4. Sex Female	5. Color or race White	6. (a) Single, married, widowed, or divorced Widowed
------------------	---------------------------	---

B.(b) Name of husband or wife..... Jacob Moody Rohrer

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1873

8. AGE: Years 73 Months 10 Days 12 If less than one day  
hrs. min.

9. Birthplace Gapland-Washington-Maryland  
(Town, county, and state)

10. Usual occupation..... Home Duties

11. Industry or business

MOTHER FATHER	12. Name..... Daniel C. Grove
---------------	-------------------------------

MOTHER FATHER	13. Birthplace..... Middletown, Maryland
---------------	--

MOTHER FATHER	14. Maiden name..... Julia Huffer
---------------	-----------------------------------

MOTHER FATHER	15. Birthplace..... Middletown, Maryland
---------------	--

16. Informant..... Mr. Arthur Rohrer

Address Boonsboro, Md. R. F. D.

17. Burial..... Rohrersville  
(Burial, cremation, or removal. Which?) Date thereof..... Sept. 28, 1947  
(month) (day) (year)

Cemetery or crematory..... Rohrersville

Location..... Rohrersville, Md

18. Funeral director..... R. I. Earnshaw

Address Keedysville, Md

19. Registrar..... G. W. Bellay M.D.  
(Date rec'd by registrar) Sept. 27, 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 26, 1947, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 2, 1947, to Sept. 26, 1947,  
and that I last saw her alive on Sept. 26, 1947.

Immediate cause of death.....

Carcinoma of colon

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... G. W. Bellay M.D.

M. D. or other.....  
Address..... Boonsboro, Md. Date signed..... Sept. 27, 1947

RECEIVED

SEP 30 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1276

08334

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

245

## 1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

25 years

How long in above place of death?

Hospital, institution, or street address where death occurred: Washington County Hospital

How long in hospital or institution? 25 days

## 3. (a) FULL NAME

Jennie Shipley

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife John Shipley

7. Birth date of deceased (mo. day. yr.) October 16, 1882

6. (c) If alive, give age years

8. AGE: Years Months Days It less than one day

64 11 hrs. min.

9. Birthplace Shepherdstown, W. Va.

(Town, county, and state)

10. Usual occupation Housework

## 11. Industry or business

12. Name John H. Hill

13. Birthplace Winchester, Virginia

14. Maiden name Martha Hawn

15. Birthplace Winchester, Virginia

16. Informant Mrs. Alma Carroll

Address Hagerstown, Maryland

17. Burial Date thereof 9-18-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. View Cemetery

Location Sharpsburg, Maryland

18. Funeral director C. M. Suter &amp; Sons

Address Hagerstown, Maryland

19. Date rec'd by registrar Sept. 17, 47 by Ernest Powers

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 533 Maryland Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1947 4:32 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28, 1947 to Sept. 16, 1947 and that I last saw her alive on Sept. 15, 1947

Immediate cause of death

Cholecystostomy

DURATION 8-22-47

Pneumonia Bronchitis

9-4-47

Due to Pharyngitis Gastroenteritis

25 yr

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Obstructed Gall-Bile

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

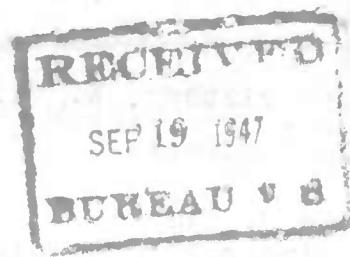
Injured at work?

23. SIGNATURE

W. Howard George  
Hagerstown, Md.

M. D. or other

Date signed 9-16-47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92d

08335

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

## 1. PLACE OF DEATH:

County.....

Washington

City or town..... Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 63 years

Hospital, institution, or street address where death occurred:

866 Virginia Ave.

Now long in hospital or institution?.....

## 3. (a) FULL NAME

Catherine Elizabeth Siepelanger none

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife..... Conrad A. Siepelanger

6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

January 9-1852

8. AGE: Years Months Days If less than one day

95 8 - . hrs. . min.

9. Birthplace..... Hesse Darmstadt, Germany

(Town, county, and state)

10. Usual occupation..... Housework

## 11. Industry or business

12. Name..... Siepelanger

13. Birthplace..... Germany

14. Maiden name..... not known

15. Birthplace..... Germany

16. Informant..... Miss Lydia Siepelanger

Address..... Hagerstown, Maryland

17. Burial..... Burial Date thereof..... 9-11-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill Cemetery

Location..... Hagerstown, Maryland

18. Funeral director..... C. M. Suter &amp; Sons

Address..... Hagerstown, Maryland

19. Death..... Sept 9, 1947

(Date rec'd by registrar) Health Powers

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington

City or town..... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 866 Virginia Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

9/8- 1947 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1 1947 to 9/8 1947

and that I last saw her alive on 9/6 1947

Immediate cause of death.....

arterio-sclerotic  
Chronic Endocarditis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

20

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

Injured at work?

23. SIGNATURE.....

M. VICTOR MILLER

M. or other

Address..... 131 W. WASHINGTON ST

Date signed..... 9/9 1947





17

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF STILLBIRTH

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

Birch and Death 157e 302  
Reg. Dist. No. 08336

1. PLACE OF BIRTH:

County Washington

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution:

Washington County Hospital

Length of mother's stay in County 1 day

(How many years, or months, or days. SPECIFY WHICH)

3. Name of child Baby Girl Statler

4. Sex Female 6. Twin or triplet —

FATHER OF CHILD

8. Full name Lawrence Richard Statler

9. Color white 10. Age at time of this birth 20 yrs.

11. Usual occupation laborer - Victor Products

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1  
(b) How many other children were born alive but are now dead? 0  
(c) How many other children were born dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of None

19. Labor: (a) Complications of None  
(b) Induced? No

20. (a) Was there an operation for delivery? Amniotomy (Yes or No)  
(b) State all operations, if any

(c) Did child die before operation? No  
During operation? No

23. (a) 13 (Burial, cremation or removal) (b) Date thereof 9/20/47 (month) (day) (year)

(c) Cemetery or crematory Brownsville

24. (a) Funeral director A. E. Mangum  
(b) Address Green Castle TQ

2. USUAL RESIDENCE OF MOTHER:

State Pennsylvania

County Franklin

City or town Greencastle

(If outside city or town limits, write RURAL and give nearest town)

Street No. 111 #3

(If RURAL give LOCATION) ✓

4. Date of birth September 19, 1947 Hour 8:28 P.M. 525

7. No. of weeks pregnancy 40 weeks

MOTHER OF CHILD

12. Full maiden name Wanda Joan May Hugh

13. Color white 14. Age at time of this birth 22 yrs.

15. Usual occupation Housewife

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Congenital heart disease - dysrhythmia

(b) Maternal causes None

22. I certify to the birth of this child who was born dead\* on the date and hour above stated.

Signature Robert F. Radde, M.D.  
(Specify if M. D., midwife, or other)

Address

25. (a) Sept. 20, 1947 (b) Chester County  
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)  
The above certificate has been examined by me.

Health Officer, per

RECEIVED

SEP 23 1947

BUREAU F B I

Will you kindly complete  
The copy of this certificate  
Two words I can not  
read with certainty.

Chas H. Bowes  
Loc Reg.

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08337

## CERTIFICATE OF DEATH

46f X  
3rd  
Reg. Dist. No.....

## 1. PLACE OF DEATH:

County..... Washington

City or town..... Rural-Sharpsburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Carrie Evelyn Thomas

3. (b) Social Security Number  
None

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife..... Reason--deceased

6. (c) If alive, give age..... years

7. Birth date of  
deceased (mo. day, yr.)

Oct. 21, 1889

8. AGE:

Years

Months

Days

If less than one day

.... hrs. .... min.

9. Birthplace..... Downsville-Wash.-Maryland  
(Town, county, and state)

10. Usual occupation.....

Home Duties

11. Industry or business

12. Name..... Charles Keets

13. Birthplace..... Keedysville, Md

14. Maiden name..... Martha Butler

15. Birthplace..... Burkettsville, Md

16. Informant..... Mrs. V. M. Knode

Address..... Rural-Sharpsburg, Md

17. Burial..... Date thereof..... Sept. 16, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Red-Hill

Location..... Rural-Keedysville

18. Funeral director..... R. I. Earnshaw

Address..... Keedysville, Md

19. 9-16 47 G. W. Lelley, M.D.  
(Date rec'd by registrar) Registrars

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Washington

City or town..... Rural-Sharpsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 14, 1947, at 3:10A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 15, 1947, to Sept. 14, 1947,  
and that I last saw her alive on Sept. 10, 1947.

Immediate cause of death.....

Carcinoma of liver.

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

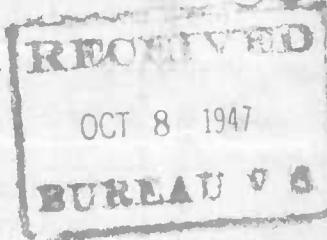
Means of injury.....

Injured at work?

23. SIGNATURE..... G. W. Lelley, M.D.

M. D. or other

Address..... Bonduvor Date signed 9-17-47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

161a

08338

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County

Washington

City or town

Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Wash. Co. Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Helen Andrew Trittapoe

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife

Single

6. (c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)

September 7 - 1947

8. AGE:

Years

Months

Days

If less than one day

hrs.

30

min.

9. Birthplace

Hagerstown Md.

(Town, county, and state)

10. Usual occupation

—

11. Industry or business

Robert Trittapoe

MOTHER FATHER

Brownsville Wash. Co. Md.

13. Birthplace

Dorothy Mullerney

14. Maiden name

Hagerstown Wash. Co. Md.

15. Birthplace

Robert Trittapoe

16. Informant

Address

Brownsville Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Church of the Brethren Cemetery

Location

Brownsville Md.

18. Funeral director

Address

Clyde Bassett

Lew. J. Bassett Son

Address

Brownsville Md.

19. Sept. 8. 47

19

Death

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Washington

City or town

Brownsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Main Street

(If rural, give LOCATION)

no

2.(a) Is veteran, name war

## 3. (b) Social Security Number

- none -

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7,

19. 47 at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

19.....

and that I last saw h..... alive on.....

19.....

Immediate cause of death.....

Asphyxia and anemia due to

Due to..... maternal placenta previae

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Caesarean, as above

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

No

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

M. D. Father

Hagerstown, Md.

Date signed 9/8/47

RECEIVED

SEP 10 1947

BUREAU F B I

08339

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

151a

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Life

Now long in above place of death?

Hospital, Institution, or street address where death occurred:

903 Potomac Avenue

Now long in hospital or institution?

## 3. (a) FULL NAME

Clinton Trovinger

4. Sex

5. Color or race

8. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Mamie Trovinger

7. Birth date of deceased (mo. day yr.)

August 3, 1864

6. (c) If alive, give age 74 years

8. AGE:

Years

Months

Days

If less than one day

83

1

13

hrs.

min.

9. Birthplace

Chewsville, Wash. Co. Md.

(Town, county, and state)

10. Usual occupation

Building Contractor

11. Industry or business

MOTHER FATHER

Joseph Trovinger

13. Birthplace

Leitersburg, Maryland

14. Maiden name

Susan Yeakle

15. Birthplace

Not Known

16. Informant

Mrs. Clinton Trovinger

Address

Hagerstown, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 9-18-47

(month) (day) (year)

Rose Hill Cemetery

Cemetery or crematory

Location

Hagerstown, Maryland

18. Funeral director

C. M. Suter &amp; Sons

Address

Hagerstown, Maryland

19. (Date rec'd by Registrar)

Sept. 17, 1947

Chart Number

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The first age  
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 903 Potomac Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 16, 1947, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 5, 1947, to Sept. 16, 1947, and that I last saw him alive on Sept. 16, 1947.

Immediate cause of death

Cardiovascular  
& Renal Disease

DURATION

July 5, 1947

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

None

Date of op.

No

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Howard Jeager

M. D. or other

Address

Hagerstown, Md.

Date signed

Sept. 16, 1947

RECEIVED

SEP 19 1947

BUREAU C A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

180

08340

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington  
 County: Hagerstown  
 City or town: (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 28 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 For newborn infants give residence of mother  
 State: Maryland County: Washington  
 City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)  
 Street No.: 49 W. Bethel Street (If rural, give LOCATION)

## 3. (a) FULL NAME

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Negro	Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years      Months      Days      If less than one day

9. Birthplace (Town, county, and state)

10. Usual occupation.

11. Industry or business

FATHER 12. Name

MOTHER 13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

Burial (Burial, cremation, or removal Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1947 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. , to . 19. , to . 19. , to . 19. , to .

and that I last saw h. alive on .

Immediate cause of death

DURATION

3rd & 4 th degree

Due to. burns of entire body

Due to.

Other conditions.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of 9/28/47

Where did injury occur? Hagers town Wash. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

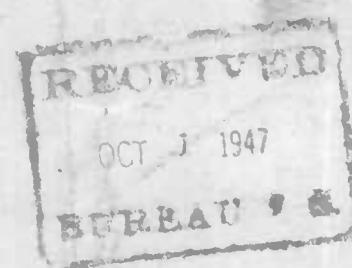
Means of Injury Burned in house Injured at work? No

23. SIGNATURE

W. R. Reiley, M.D. DEPUTY MEDICAL EXAM.

WASH. CO., MD.

Hagerstown, Md. Date signed 9/29/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore

129

08341

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

302

## 1. PLACE OF DEATH

County.....

Washington

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 week

Hospital, institution, or street, address where death occurred:

Washington Co Hospital

How long in hospital or institution?..... 1 week

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Hanty Md  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... non

(If rural, give LOCATION)

✓

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Maurice Fisher Willard

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

white

Single

B.(b) Name of husband or wife.....

7. Birth date

deceased

(Mo. Day Yr.)

8-27-1898

6.(c) If alive, give age..... years

8. AGE:

Years Months Days If less than one day

49-

11

— hrs.

min.

9. Birthplace.....

10. Usual occupation.....

## 11. Industry or business

12. Name.....

FATHER

13. Birthplace

14. Maiden name.....

MOTHER

15. Birthplace

16. Informant.....

Address

17. Burial

(Burial, cremation, or removal. Where?)

Cemetery or crematory

Location

18. Funeral director.....

Address

19. (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

8 Sept

19. 47 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

I Sept 19. 47 to 8 Sept 19. 47

and that I last saw h. 12 alive on 7 Sept 19. 47

Immediate cause of death.....

Pneumonia acute.

Due to... Perforated Ulcer.

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of...

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... 110 W. Market 8 Sept 47 Date signed.....

233

RECEIVED

SEP 10 1947

BUREAU F B

Dr. Wells  
08342

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM NO. G. 115 APR 27 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 708

PLEASE WRITE PLAINLY, WITH  
BLACK INK. Supply every item of information carefully. The correct  
age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
County Washington

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? En route to Hagerstown

Hospital, institution, or street address where death occurred: One U.S. # 40 10 mi West of

How long in hospital or institution? Hagerstown, Ind.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ohio County Summit

City or town Akron  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 39 Fulton St

(If rural, give LOCATION)

None

2.(a) If veteran, name war.....

3. (b) Social Security Number

298-01-9941

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 3 1947 19 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on

Immediate cause of death

DURATION

Open fracture and  
avulsion of skull

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of Sept. 3-47

Where did injury occur? Wardsburg Rd Pa.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

(Injury) (Cause)

Means致死原因: Auto struck by motor vehicle

Deputy and Frau

23. SIGNATURES Dr Robert Wells Work Co. Md.

M. D. or

Address Hagerstown, Md Date signed Sept. 4-47

Authorization for correction is made by John H. Coffman Atty. at Law at the request of  
Velma Wilson widow of deceased.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

501

08343806

## CERTIFICATE OF DEATH

Reg. Dlat. No. 144

M  
The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

R

## 1. PLACE OF DEATH:

County..... Washington

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Ritchie Hospital

How long in hospital or institution?

5 days

## 3. (a) FULL NAME

Marie Rosalie Thordson

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FWhite Married

6. (b) Name of husband or wife.....

Daniel P. Thordson

7. Birth date of deceased (mo., day, yr.)

May 19 19028. (c) If alive, give age 49 years

8. AGE:

45 Years 3 Months 25 Days

If less than one day

hrs. min.

9. Birthplace..... New York  
(Town, county, and state).10. Usual occupation..... Housewife

## 11. Industry or business

12. Name..... Daniel Rosalie13. Birthplace..... New York14. Maiden name..... Lorraine Rose Naughton15. Birthplace..... New York16. Informant..... Hospital CoronerAddress..... Hospital17. Transportation..... Transportation  
(Burial, cremation, or removal. Which?)Date thereof, Sept 15 1947  
(month) (day) (year)Cemetery or crematory..... BaltimoreLocation..... State - New York18. Funeral director..... M. L. Creaghead Son  
Address..... Thurmont, Md.19. Sept. 15 1947  
(Date rec'd by registrar) Blanche S. Epler  
Registrar Geo. H. Ferguson

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....City or town..... Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 9th Preston St  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept 14 1947, at 7 50 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 9 1947, to Sept 14 1947 and that I last saw her alive on Sept 13 1947.

Immediate cause of death.....

Carcinomatosis, extensiveDue to..... Pneumonia of Breast 9 mo.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

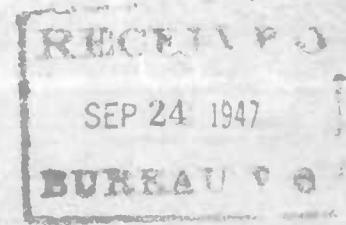
Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE..... Thomas M. Armstrong, M.D.  
M. D. or otherAddress..... Ritchie Hosp. Cascade, Md. Date signed Sept 14, 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

08344

## CERTIFICATE OF DEATH

Reg. Dist. No. 316

1. PLACE OF DEATH:  
 County Washington  
 City or town Keedysville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 60 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Keedysville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war:

3. (a) FULL NAME  
 Henry Kyd Zimmerman

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Married	
6. (b) Name of husband or wife Lillie M. Zimmerman			
7. Birth date of deceased (mo., day, yr.) June 4, 1882			
B. (c) If alive, give age 62 years			
8. AGE: 65	Years 3	Months 24	Days If less than one day hrs. min.
9. Birthplace Sharpsburg-Wash.-Maryland (Town, county, and state)			
10. Usual occupation Merchant			
11. Industry or business			
FATHER 12. Name Nicodemus Zimmerman			
MOTHER 13. Birthplace Eakle's Mill, Md			
MOTHER 14. Maiden name Rosanna Snyder			
MOTHER 15. Birthplace Eakle's Mill			
16. Informant Mrs. Lillie Zimmerman			
Address Keedysville, Md			
17. Burial (Burial, cremation, or removal. Which?) Sept. 30, 1947			Date thereof (month) (day) (year)
Cemetery or crematory Fair-View			
Location Keedysville, Md			
18. Funeral director R. I. Earnshaw			
Address Keedysville, Md			
19. (Date rec'd by registrar) Sept. 30, 1947			Registrars Signature Date signed 9/29/47

3. (b) Social Security Number None

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Sept. 28 1947 at 7:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 18 1947 to Sept. 28 1947 and that I last saw him alive on Sept. 27 1947.

Immediate cause of death Anorectal fistulation

Due to Chronic nephritis

DURATION 7 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Kyd Zimmerman M.D.

M. D. or other

Address 131a, Baltimore, Md. Date signed 9/29/47

RECEIVED

OCT 3 1947

BURTON LIBRARY